EVANSTON NORTHWESTERN HEALTHCARE

Admission	Admission Date	Admission Type	Discharge Date
	9/14/2007 (Initial)	EMERGENCY	9/20/2007

Patient Demographics

Name	Patient ID	SSN	Sex	Birthdate
VENTRELLA,BERENICE	011293677	xxx-xx-7386	Female	3/18/1919 (88 yrs)

Address	Phone	EMail	Employer
2311 DORINA DRNORTHFIELD, IL 60093	847-441-7747(H)		NONE

Reg Status	PCP	Date Last Verified	Next Review Date
VERIFIED	SHAPIRO, SUSAN D,847-729-8833	5/13/2005	

Allergies: (No Known Allergies) Date Reviewed: 09/20/2007

Problem List

Problem	Noted	Resolved
ACUTE MYOCARDIAL INFARCT(aka MYOCARDIAL) [410]	4/17/2003 by SHAPIRO, SUSAN D.	5/15/2003 by SHAPIRO, SUSAN D.
CONGESTIVE HEART FAILURE [428.0] Class: Active	5/13/2005 by SHAPIRO, SUSAN D.	No
DIABETES MELLITUS [250] Class: Active	4/17/2003 by SHAPIRO, SUSAN D.	No
BACKACHE NOS(aka BACK PAIN) [724.5] Class: Acute	5/15/2003 by SHAPIRO, SUSAN D.	5/17/2005 by SHAPIRO, SUSAN D.
BENIGN HYPERTENSION [401.1]	9/30/2003 by WISDOM, PAULINE E	No
ACUTE RESPIRATORY FAILURE [518.81] Class: Active	5/13/2005 by INTERFACE, REG/ ADT INCOMING	9/17/2007 by SHAPIRO, SUSAN D.
CHR ISCHEMIC HRT DIS NOS [414.9]	5/17/2005 by SHAPIRO, SUSAN D.	No
MITRAL/AORTIC STENOSIS [396.0]	5/17/2005 by SHAPIRO, SUSAN D.	No
ED DIAGNOSIS [999998] Comment: altered mental status	9/14/2007 by INTERFACE, REG/ ADT INCOMING	9/17/2007 by SHAPIRO, SUSAN D.
Urinary Tract Infection, Site not Specified [599.0]	9/14/2007 by INTERFACE, REG/ ADT INCOMING	No
Hallucinations [780.1]	9/17/2007 by SHAPIRO, SUSAN D.	No
Urinary Retention [788.20B] Class: Acute	9/17/2007 by SHAPIRO, SUSAN D.	No

Chief Complaint

MENTAL STATUS CHANGES

Reason for Admission

ED DIAGNOSIS [999998]	altered mental status
Urinary Tract Infection, Site not Specified [599.0]	

END OF REPORT

Ex. B

Consult Notes

All notes

Author	Service	Author Type	Filed
Sadiya Khan	(none)	Medical Student	09/15/2007 1109

Note Status
Revised

Related Notes
Cosigned by : PATEL, SMITA at 09/15/2007 1229
Addendum by : PATEL, SMITA at 09/15/2007 1229

M3 Student Note (Neurology Consult)
Reason for consult: Mental status changes
Sources: patient and previous records

HPI:
This is a 88 year old female with PMH of DM, CHF, CAD, and ishcemic cardiomyopathy who presented to the ER for evaluation of acute mental status changes. Patient states that for the past five days she has been unable to sleep because of all the "commotion" with the angels, prior business partners, and dancing ocurring at home. Patient denies currently seeing any angels, but continues to question the presence of other people in the room and began talking to someone else during the interview. When asked who she was talking to, patient stated, "the 10 other people in the room". However, patient has history of cataracts and vision is grossly impaired. Patient denies any auditory hallucinations. On further questioning patient states that she has been seeing these angels for almost a year.

Patient is not able to get out of bed and according to the chart has not walked in over 6 months. Patient states that she had a fall 8 months, PT was attempted but not sucessfully completed because she did not like them. Patient states that she has a walker at home, but stays completely in bed, using a bedpan to relieve herself. Patient states that her diet is mostly liquid including oatmeal and juices.

Patient denies any active complaints and states that she was simply brought in to the ER for a "check-up" and would like to go home. Patient lives at home with her husband and son who care for her. Patient is actively involved in business deals concerning real estate exchanges and her business partner states that he has noticed any change in intelligence, concentration, or business sense.

PMH:
DM, CAD, Ischemic cardiomyopathy, CHF
2 prior MIs

PSH:
No past surgical history on file.

Allergies:
No Known Allergies.

Medications:
Lasix 40 mg QD
Potassium 10 mEq BID

Note Status Related Notes

Coreg 25 mg BID
Humilin 70/30 7 U before breakfast and 3 U before dinner
Imdur 30 mg daily
Quinipril 20 mg BID
Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN), 325 mg,
Ciprofloxacin 400 mg (CIPRO), 400 mg, Intravenous, NOW THEN Q24HR,
Heparin SOLN 5,000 Units (HEPARIN), 5000 Units, Subcutaneous, Q8HR, ALI, AMAN

Social History:
Patient lives with husband and son and is actively still involved in running her own business with partner dealing with real estate.

Physical Exam:

BP:
133/59

Pulse:
69

Temp:
98.1 F (36.7 C)

Resp:
16

Height:
4' 8" (1.422 m)

Weight:
99 lbs 8.0 oz (45.133 kg)

General: NAD
CV: rr, no m/r/g, no peripheral edema, no carotid bruit
Lung: CTAB
Neuro:
Mental Status: alert and oriented to person, place, and time.
Tangential thought process with persistent visual hallucinations of people and angels in room. Recall 2/3 immediately and 2/3 at 5 minutes. MMSE showed deficits in concentration and memory and was unable to complete because patient is unable to see bilaterally due to cataracts.
CN II, III, IV, VI: patient unable to follow light, finger, but can point to where I am sitting; pupils equal and reactive to light.
CN V: mastication and sensation intact
CN VIII: hearing grossly intact to finger rub bilaterally
CN IX, X: palate strong and midline
CN XI: trapezius/scm 5/5
CN XII: tongue midline

Motor:
Tone normal and power diminished in LE 4/5 with atrophy of lower leg muscles; UE 5/5. No pronator drift, tremor, or rigidity. Arthritic changes noted in feet.
Sensory: decreased vibration and position sense in LE; intact sensation to pinprick, temperature and light touch. Babinski flexor responses bilaterally.
Reflexes:
2+ throughout
Coordination/Gait:
FTN performed with difficulty. Unable to get out of bed.

Impression:
1. Long term visual hallucinations, possibly exacerbated by recent UTI not consistent with dementia.

Plan:
1. Continue present management
2. Consider benzodiazepine for sleep if insomnia persists.

Author	Service	Author Type	Filed
Smita Patel	(none)	Physician	09/15/2007 1229

Related Notes
Related note : KHAN, SADIYA at 09/15/2007 1109
Original Note : KHAN, SADIYA at 09/15/2007 1109

M3 Student Note (Neurology Consult)
Reason for consult: Mental status changes
Sources: patient and previous records
Requesting physician: Dr. Unger

HPI:
This is a 88 year old female with PMH of DM, CHF, CAD, and ischemic cardiomyopathy who presented to the ER for evaluation of acute mental status changes. Patient states that for the past five days she has been unable to sleep because of all the "commotion" with the angels, prior business partners, and dancing ocurring at home. Patient denies currently seeing any angels, but continues to question the presence of other people in the room and began talking to someone else during the interview. When asked who she was talking to, patient stated, "the 10 other people in the room". However, patient has history of cataracts and vision is grossly impaired. Patient denies any auditory hallucinations. On further questioning patient states that she has been seeing these angels for almost a year.
Patient is not able to get out of bed and according to the chart has not walked in over 6 months. Patient states that she had a fall 8 months, PT was attempted but not sucessfully completed because she did not like them. Patient states that she has a walker at home, but stays completely

in bed, using a bedpan to relieve herself. Patient states that her diet is mostly liquid including oatmeal and juices.

Patient denies any active complaints and states that she was simply brought in to the ER for a "check-up" and would like to go home. Patient lives at home with her husband and son who care for her. Patient is actively involved in business deals concerning real estate exchanges and her business partner states that he has noticed any change in intelligence, concentration, or business sense.

PMH:
DM, CAD, Ischemic cardiomyopathy, CHF
2 prior MIs

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Allergies:
No Known Allergies.

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Potassium 10 mEq BID
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Social History:
Patient lives with husband and son and is actively still involved in running her own business with partner dealing with real estate.

Physical Exam:

BP:
133/59

Pulse:
69

Temp:
98.1 F (36.7 C)

Resp:
16

Related Notes

Height:
4' 8" (1.422 m)

Weight:
99 lbs 8.0 oz (45.133 kg)

General: NAD
CV: rrr, no m/r/g, no peripheral edema, no carotid bruit
Lung: CTAB
Neuro:
Mental Status: alert and oriented to person, place, and time. Tangential thought process with persistent visual hallucinations of people and angels in room. Recall 2/3 immediately and 2/3 at 5 minutes. MMSE showed deficits in concentration and memory and was unable to complete because patient is unable to see bilaterally due to cataracts.
CN II, III, IV, VI: patient unable to follow light, finger, but can point to where I am sitting; pupils equal and reactive to light.
CN V: mastication and sensation intact
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Motor:
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Sensory: decreased vibration and position sense in LE; intact sensation to pinprick, temperature and light touch. Babinski flexor responses bilaterally.
Reflexes:
2+ throughout
Coordination/Gait:
FTN performed with difficulty. Unable to get out of bed.

Impression:
1. Long term visual hallucinations, possibly exacerbated by recent UTI not consistent with dementia.

Plan:
1. Continue present management
2. Consider benzodiazepine for sleep if insomnia persists.
Sadiya Khan

I performed a history and physical examination of Berenice Ventrella and discussed her management with the medical student. I reviewed the student's note and agree with the documented findings and plan of care except where indicated

HPI:
requesting Physician: Dr. Unger
Reason for referral: MS changes with hallucinations
Source: patient and her husband over the phone

This is a an 88 year old lady with multiple medical problems who presents with 1 year to 6 months of hallucinations while at home. When talking to her husband if anything else is going on, he states, "no. just wanted to get her checked out." According to him, she is with it some days and not so clear other days. She has been sitting in her bed and usually gives orders to everyone. In the house, live her husband and son,Nick. Nick seems to be in charge of her medical care and gives her medications, etc. Angelo states he is in charge of the cleaning up. She has not been getting up to use the bathroom. Angelo gives her a sponge bath every now and then.
Nick takes care of the finances but her business partner John who was here to visit her this AM, states she has been pretty with it so far.
Angelo agrees that she seems to know her business stocks etc.
When I first walked in the room, Berenice was talking to herself or to angels. She waited for a response and seemed to answer back. She denies hearing her hallucinations but does admit to seeing her parents, othe people. She never tres to chase them because she can not walk. She does not appear to be harmed by them. She does state that her sleep was poor because they keep her awake.
She has only one compliant and that is some pain in the right lower leg with palpation.
She is also aware she is in the hospital for the hallucinations.

Current hospital medications:
Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Insulin Human 70/30 SUSP 7 Units (HUMULIN 70/30)
AC BREAKFAST

Insulin Human 70/30 SUSP 3 Units (HUMULIN 70/30)
AC DINNER

Insulin (Aspart) Correction Table (Novolog)
ACHS

Glucose CHEW 16 g (GLUCOSE)
Q15MINPRN

Dextrose SOLN 12.5-25 g (DEXTROSE)

Related Notes
Q15MINPRN

Glucagon SOLR 1 mg (GLUCAGEN)
Q15MINPRN

Ciprofloxacin 400 mg (CIPRO)
NOW THEN Q24HR

Furosemide TABS 40 mg (LASIX)
DAILY

Carvedilol TABS 25 mg (COREG)
BID

Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Past medical history: CHF, CAD, DM, ischemic cardiomyopathy
Past surgical hx: none
Family hx: non- contributory
Allergies: as noted in chart, epic
Social history: lives in her house for many years - now with her husband and her oldest son, Nick. She has a chair lift in her house but does not use and just stays in her bedroom. Denies alcohol or tobacco
Review of systems: All systems were discussed with the patient, including cardiac and respiratory, and were negative and as per HPI.

Vitals: BP 133/59 | Pulse 69 | Temp 98.1 F (36.7 C) | Resp 16 | Ht 4' 8" (1.422 m) | Wt 45.133 kg (99 lbs 8.0 oz)
Mental status:
1) Alert and orient x3, aware of past presidents in order until reagan. She was able to name 14 animals in one minute. She is aware of what happened on 911 and recalls the tsunami and Katrina. She did not recall the name of the hurricane but knew it was a hurricane.
She was able to repeat 3 object and recalls 1/3 agter distraction. She was able to trails b until 10 J. She was abe to do serial 7's and spell world forwards and backwards. She could follow complex commands. She can not see very well and was not given a clock to draw or reading materials.
She was able to give history of her childhood and this was confirmed with her husband who admits the hx is correct.
She was slightly tagential but she was able to refocus.

General: dishelved appearance and uncombed hair. Slight smell to her as well. language and speech intact
Chest: clear to auscultation and percussion
Heart: regular rate and rhythm with normal S1 and S2

Related Notes

Neurologic:
CRANIAL NERVES:
Cranial Nerve II: Visual Fields can not be tested d/t bil cataracts and can only see shadows and light. Pupils equal round and reactive to light.
Cranial Nerves III, IV, VI: EOM full without dyscongugate gaze- able to follow light and commands to look right, left, up down, No nystagmus. No Ptosis
Cranial Nerve V: Mastication intact. Facial Sensation normal
Cranial Nerve VII: Face is symmetrical
Cranial Nerve VIII: Hearing grossly intact bilaterally to finger rub
Cranial Nerve IX, X: Palate elevation midline
Cranial Nerve XI: Sternocleidomastoid and Trapezius Muscles are symmetrical and normal in power
Cranial Nerve XII: Tongue protrudes midline without atrophy or fasciculations
MOTOR EXAM:
Good power in all four extremties with atrophy in bil distal extremities and lower extremities. No fasciculations. Tone is normal.
No tremor at rest, posture, or intention. No cogwheeling or rigidity.
RELFEXES:
Symmetrical hypoactive reflexes in the upper and lower extremities. No achilles reflexes bilaterally, no biceps reflex on right
Babinski Flexor response bilaterally
SENSATION:
Intact sensation to pin, and decreased vibration withdraws to painful stimuli
COORDINATION:
difficult to test as patient can not see instructions. She had difficulty finding her nose bilaterally. No obvious ataxia, Slight postural tremor bilaterally
GAIT and STANCE:
did not test as patient has not been walking in several months after a injury

Laboratories/ Imaging:
I reviewed pertinent labs in epic and CTOH in pacs personally

Impression/ recommendations:
1) Hallucinations - ongoing for at least the last 6 months to 1 year per family and business partner. Not contributing to harm to herself or others. If sleep affected by it, could consider a mild sedative for sleep such as temezapam or seroquel 12.5 mg. No other neurological signs to suggest dementia or parkinsonism(Lewy body disease) or stroke. She did fairly well on testing and perhaps got her at a good time. Her memory should probably be followed as an outpatient.
Per family she has been having hallucinations for some time now and they just wanted to get her checked out. UTI was found and could contribute to her fluctuation. Agree with UTI treatment.

2) Please call with concerns
3) Paged Dr. Unger to discuss above, will await call back.

Smita Patel, D.O.
Department of Neurology

Related Notes
Pager 2740

Author	Service	Author Type	Filed
Smita Patel	(none)	Physician	09/16/2007 1107

Procedure
1. NEUROLOGY CONSULT (IP) [83958776] ordered by ALI, AMAN at 09/14/07 2045

Neurology Attending Note

September 16, 2007

Patient seen this AM and again was seen to be talking to herself this Am. the coversation seemed approriate in that she was talking about how she can not really see weell due to her cataracts. She would not call herself blind because she can still see light. When i interuppted her talking, she did recall who I was based on voice. She states she recalls the 3 objects i asked her to remember yesterday spontaneously and was able to state all 3 correctly.
She has no complaints this AM and feels that she could go home. If she does not go home, she would be giving her husband and son a break and some rest,

All systems were discussed with the patient, including cardiac and respiratory, and were negative and as per HPI.

Current hospital medications:
Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Insulin Human 70/30 SUSP 7 Units (HUMULIN 70/30)
AC BREAKFAST

Insulin Human 70/30 SUSP 3 Units (HUMULIN 70/30)

Procedure
AC DINNER

Insulin (Aspart) Correction Table (Novolog)
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Glucose CHEW 16 g (GLUCOSE)
Q15MINPRN

Dextrose SOLN 12.5-25 g (DEXTROSE)
Q15MINPRN

Glucagon SOLR 1 mg (GLUCAGEN)
Q15MINPRN

Ciprofloxacin 400 mg (CIPRO)
NOW THEN Q24HR

Furosemide TABS 40 mg (LASIX)
DAILY

Carvedilol TABS 25 mg (COREG)
BID

Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

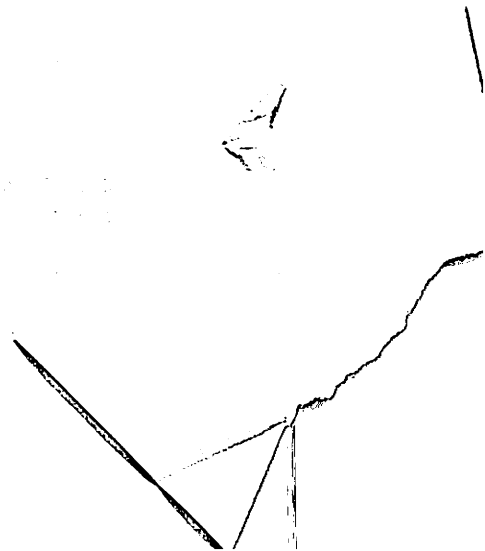
Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Vs: BP 137/56 | Pulse 72 | Temp 98.3 F (36.8 C) | Resp 20 | Ht 4' 8" (1.422 m) | Wt 97 lbs 12.8 oz (44.362 kg)
Neuro exam unchanged from yesterday. and MS appears intact. No signs of fluctuation based on 2 visits with her and with medical student observations as well.

Labs: reviewed in EPIC

Impression/ recommendations:

Hallucinations - ongoing for at least the last 6 months to 1 year per family and business partner. Not contributing to harm to herself or others. If sleep affected by it, could consider a mild sedative for sleep such as temezapam or seroquel 12.5 mg. No other neurological signs to suggest dementia or parkinsonism(Lewy body disease) or stroke. She did fairly well on testing. No signs of MS fluctuations. Her memory should probably be followed as an outpatient.
Per family she has been having hallucinations for some time now and they just wanted to get her checked out. UTI was found and could contribute to her fluctuation. Agree with UTI treatment please call with changes



CONSULTATION NOTE - Epic Ext#10670535

Procedure

Smita Patel, D.O.
Department of Neurology
Pager 2740

Author	Service	Author Type	Filed
Michael Shane McGuire	(none)	Physician	09/17/2007 1430

CC: Berenice Ventrella (xxx-xx-7386), is a 88YO female referred by SUSAN SHAPIRO, MD for a consultation regarding retention.

HPI: Symptoms: incomplete emptying
Location: bladder
Duration: unknown
Associated findings: pyuria and confusion
Modifying factors: pvr 350cc

Past Medical History

ACCIDENTAL FALL FROM BED
2/2/03

SHORTNESS OF BREATH
2000

UNSPECIFIED CHRONIC ISCHEMIC HEART DISEASE
1999

DIABETES MELLITUS
1990

ACUTE MYOCARDIAL INFARCT(aka MYOCARDIAL)
4/17/2003

CONGESTIVE HEART FAILURE
4/17/2003

BACKACHE NOS(aka BACK PAIN)
5/15/2003

Author | Service | Author Type | Filed

No past surgical history on file.

Meds:

Current hospital medications:
Insulin Human 70/30 SUSP 8 Units (HUMULIN 70/30)
AC BREAKFAST

Insulin Human 70/30 SUSP 4 Units (HUMULIN 70/30)
AC DINNER

Quetiapine TABS 12.5 mg (SEROQUEL)
QHS

Ciprofloxacin TABS 500 mg (CIPRO)
NOW THEN Q24HR

Insulin (Aspart) Correction Table (Novolog)
ACHS

Pneumococcal (PNEUMOVAX) vaccine
ONCE

Sodium Chloride flush 3 mL
FLUSH PER PROTOCOL

Aspirin Enteric-Coated TBEC 325 mg (ASPIRIN)
DAILY

NaCl 0.9% (NaCl 0.9%)
INFUSION

Glucose CHEW 16 g (GLUCOSE)
Q15MINPRN

Dextrose SOLN 12.5-25 g (DEXTROSE)
Q15MINPRN

Glucagon SOLR 1 mg (GLUCAGEN)
Q15MINPRN

Furosemide TABS 40 mg (LASIX)
DAILY

Carvedilol TABS 25 mg (COREG)
BID

Isosorbide MONOnitrate TB24 30 mg (IMDUR)
DAILY

Quinapril TABS 20 mg (ACCUPRIL)
BID

Potassium Chloride TBCR 10 mEq (K-TAB)
BID

Heparin SOLN 5,000 Units (HEPARIN)
Q8HR

Author	Service	Author Type	Filed
Berenice Ventrella		CONSULTATION NOTE/Epic Enc# 19670535	

Allergies:
Review of patient's allergies indicates no known allergies.

Social history:

Tobacco Use:
Never

Alcohol Use:
No

Family History
No family history on file.

REVIEW OF SYSTEMS:
Constitutional: - Fevers, - weight loss
eyes: - blindness, - diplopia

Physical exam:
Blood pressure 172/62, pulse 72, temperature 97.8 F (36.6 C), resp. rate 18, height 4' 8" (1.422 m), weight 45.450 kg (100 lbs 3.2 oz).
Gen Appearance NI
Mood hallucinating
Skin NI
Neck NI
Resp Effort NI
Peripheral Vasc NI
Lymphatic NI
Bldr/Kid NI
Hernia Absent
Liver/Spleen NI
Stool Not Indicated

CBC:

WBC	7.2	09/14/2007
RBC	4.30	09/14/2007
HGB	12.4	09/14/2007
HCT	36.3	09/14/2007
PLT	203	09/14/2007

BMG:

Author		Service	Author Type	Filed
GLU	152 09/17/2007			
NA	143 09/17/2007			
K	3.6 09/17/2007			
CL	110 09/17/2007			
CO2	27 09/17/2007			
BUN	31 09/17/2007			
CREAT	1.0 09/17/2007			
CA	8.7 09/17/2007			

Urinalysis:

UACOL	YELLOW	09/14/2007
UAPP	CLEAR	09/14/2007
USPG	1.015	09/14/2007
PHU	6.0	09/14/2007
UAPROT	NEGATIVE	09/14/2007
GLUUR	NEGATIVE	09/14/2007
UAKET	NEGATIVE	09/14/2007
BILI	NEGATIVE	09/14/2007
URBLD	1+	09/14/2007
NITRITE	NEGATIVE	09/14/2007
UROBIL	0.2	09/14/2007
LEUKEST	3+	09/14/2007
MUCTHRU	NONE SEEN	09/14/2007
SQEPIUR	RARE	09/14/2007
BACTU	1+	09/14/2007
WBCURINE	TNTC	09/14/2007
URBC	0-4	09/14/2007

ucx mixed flora
pvr 350cc

Impression: pyuria/ confusion/elevated pvr in elderly pt. Agree w/ treatment even though cx no specific organism. Would also check ct abd-stone protocol given pyuria. Would give decath trial in am post beginning treatment to evaluate incomplete emptying.

Plan: will follow

END OF REPORT